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* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Willie T Brown			2 SEX Male	3a TIME OF DEATH 11:25p M	3b DATE OF DEATH (Month, Day, Yr) November 21, 2001
4 *SOCIAL SECURITY NUMBER 314-24-4053	5a AGE—Last Birthday (Years) 69	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) December 15, 1931	7 BIRTHPLACE (City and State or Foreign Country) Sallis, Mississippi
8a WAS DECEDENT A U.S. VETERAN? NO	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			
9b FACILITY NAME (If not institution, give street and number) 7318 Hemlock Ave		9c CITY, TOWN, OR LOCATION OF DEATH Gary		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Mabel Hill	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Machinist		12b KIND OF BUSINESS/INDUSTRY USX	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Gary		13d STREET AND NUMBER 7318 Hemlock Avenue	
13e ZIP CODE 46403	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) Black	17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary <input type="checkbox"/> Secondary (0-12) <input checked="" type="checkbox"/> 12th <input type="checkbox"/> College (1-4 or 5+)
18 FATHER'S NAME (First, Middle, Last) Emon T. Brown			19 MOTHER'S NAME (First, Middle, Maiden Surname) Lucy Williams		
20a INFORMANT'S NAME (Type/Print) Mabel Brown		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7318 Hemlock Ave Gary, Indiana 46403		20c Relationship Wife	
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) November 26, 2001 Evergreen Cemetery		21c LOCATION—City or Town, State Hobart Indiana	
22a EMBALMER'S NAME Patrician Owens		22b EMBALMER'S LICENSE NO. 08700298		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Valerie Brown</i>		24b LICENSE NUMBER (of Licensee) #08700646		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 W. 11th Ave Gary, Indiana 46404	
26 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a Acute Myocardial Infarction		Approximate Interval Between Onset and Death 6 minutes	
		b DUE TO (OR AS A CONSEQUENCE OF) Coronary Artery Disease		2 years	
		c DUE TO (OR AS A CONSEQUENCE OF)			
		d DUE TO (OR AS A CONSEQUENCE OF)			
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Severe Hypertension, Insulin Dependent Diabetes Mellitus					
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a WAS AN AUTOPSY PERFORMED? (Yes or no) No		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No	
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> HEALTH OFFICER On the basis of examination and/or investigation in my opinion, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> CORONER On the basis of examination and/or investigation in my opinion, death occurred at the time, date, and place and due to the cause(s) and manner as stated.					
29b SIGNATURE AND TITLE OF CERTIFIER <i>George T. Clardy Jr.</i>			29c MEDICAL LICENSE NO. 01028821		29d DATE SIGNED (Month, Day, Year) November 27, 2001
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) George T. Clardy, Jr., M.D., Inc. 650 Grant St., Suite 5 Gary, IN 46404					
31 HEALTH OFFICER'S SIGNATURE <i>Valerie Brown</i>					32 DATE FILED (Month, Day, Year) NOV 29 2001
33 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
		34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34f LOCATION (Street and Number or Rural Route Number, City or Town, State) 001001	
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

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NOV 10 2004

STEPHEN R. STIGLICH COUNTY AUDITOR

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